



My Life, My Health: **Living with Chronic Conditions** Welcome to the 6- Month Follow-Up Participant Survey

This survey marks 6 months after your completion of the My Life, My Health, workshop and is the final survey in the Evaluation Program. We appreciate your participation and thank you for taking a few minutes to answer some final questions. While you may leave any question blank, we encourage you to complete the survey. Your responses are extremely helpful .

This survey asks for basic information about your health and will be compared to your responses during the workshop . At the bottom of this page please fill in your name; this is only for the purpose of matching your information with your attendance. Once matched, your name will be removed from all survey responses. Your name will not be recorded in any database. Please use the name you have used on all previous surveys.

Your form will be kept confidential. Your responses will not affect any services or programs you are getting. If you have any questions about what is being asked, please ask your Group Leader whose contact information is provided at the bottom of this page. Please return the survey as soon as possible.

Thank you again for taking time to complete this important survey and participating in our Evaluation Project !

Your Name: _____

Please Complete and Mail Back To:

Name: _____

Address: _____

City, State, Zip: _____

Phone: () _____ - _____ Email: _____

Funding provided by the U.S. Administration on Aging and managed by
the Massachusetts Executive Office of Elderly Affairs and the Department of Public Health

For Program Coordinator Use Only

Participant # _____

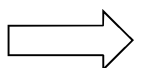
created: 5/2010

revised 8/2010

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My Life, My Health:
Living with Chronic Conditions
6-Month Follow-Up Survey

Office Use Only

Received _____

DPH _____

Participant Health Survey

Instructions:

Please use a pen to answer the questions on both sides of this form.

Please print clearly. Please fill in the circle(s) completely, like this: ●

General Health

1. In general, would you say your health is:

- ☐ Excellent
- ☐ Very Good
- ☐ Good
- ☐ Fair
- ☐ Poor

2. During the past 30 days, for about how many days did poor physical health (including physical illness and injury) keep you from doing your usual activities, such as self-care, work or recreation?

_____ days in the past month

3. During the past 30 days, for about how many days did poor mental health (which includes stress, depression, and problems with emotions) keep you from doing your usual activities, such as self-care, work or recreation?

_____ days in the past month

Please turn over



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Participant # ____ Facility Code _____ Workshop Start Date ____/____/____

Workshop Leaders _____

created: 5/2010

revised 8/2010

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Physical Activity

4. During the past week, other than your regular daily activities, did you participate in any physical activities or exercises, such as brisk walking, bicycling, dancing, etc.?
- ☐ Yes
- ☐ No
5. How many days in the past week were you physically active for at least 30 minutes such as brisk walking, bicycling, vacuuming, gardening or anything that causes you to breathe faster (it does not have to be all at one time).
- _____ days/ past week

Symptoms

For each of the following questions, please fill in the circle above **ONE** number that describes your symptoms in the past week. Zero indicates no symptom at all.

(Please remember to fill in the circles(s) completely, like this: ●)

6. We are interested in learning whether or not you are affected by fatigue. Select the number below that best describes your fatigue in the past week.

No Fatigue	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Severe Fatigue
	0	1	2	3	4	5	6	7	8	9	10	

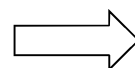
7. We are interested in learning whether or not you are affected by pain. Select the number below that best describes your pain in the past week.

No Pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Severe Pain
	0	1	2	3	4	5	6	7	8	9	10	

8. We are interested in learning whether or not you are affected by stress. Select the number below that best describes your stress in the past week.

No Stress	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Severe Stress
	0	1	2	3	4	5	6	7	8	9	10	

Please turn over



Symptoms--continued

9. We are interested in learning whether or not you are affected by sleep problems. Select the number below that best describes your sleep in the past week.

No Problem Sleeping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Very Big Problem Sleeping
	0	1	2	3	4	5	6	7	8	9	10	

Confidence Levels

(Please fill in just one circle for each of the items, like this: ☐)

10. How confident are you that you can do the different tasks and activities needed to manage your health condition so as to reduce your need to see a doctor?

Not at All Confident	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Totally Confident
	0	1	2	3	4	5	6	7	8	9	10	

11. How confident are you that you can do things other than just taking medication to reduce how much your illness affects your everyday life?

Not at All Confident	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Totally Confident
	0	1	2	3	4	5	6	7	8	9	10	

Health Care

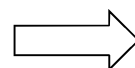
12. When you visit your doctor, how often do you prepare a list of questions for your doctor?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Never	Almost Never	Sometimes	Fairly-often	Always

13. When you visit your doctor, how often do you ask questions about the things you want to know and things you don't understand about your treatment?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Never	Almost Never	Sometimes	Fairly-often	Always

Please turn over



Health Care—continued

14. When you visit your doctor, how often do you discuss any personal problems that may be related to your illness?

☐ ☐ ☐ ☐ ☐
Never Almost Never Sometimes Fairly-often Always

15. In the past 6 months, how many times did you visit a physician?

Do not include visits while in the hospital or the hospital emergency department...... visits

16. In the past 6 months, how many times did you go to a hospital emergency department ?..... times

17. In the past 6 months, how many times were you admitted to the hospital for one night or longer?..... times

18. In the past 6 months, how many total NIGHTS did you spend in the hospital? nights

19. Were any of these hospitalizations at a skilled nursing facility , convalescent hospital, or other minimum care facility?

☐ Yes
☐ No

Thank you for your help!